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MANORCARE AT ROLLING MEADOWS	4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 25 Nasacort nose spray to each nostril for R28. During reconciliation of order, Nasacort order include instruction "should be shaken well before using." This instruction was not followed. This is a medication error.	F 332		
F 501 SS=D	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, review of policies and procedures, and clinical record reviews, the facility Medical Director did not ensure that the resident care policies were fully implemented and coordinated. Failure of the Medical Director to monitor the skin prevention program as well as the failure to assure that there was procedure in place to monitor Coumadin levels while administering this medication led to serious potential for harm to the facility residents. As a result, Immediate Jeopardy citations were cited for F309 (483.25) and F314 (483.25) during last annual survey.	F 501		6/14/07
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h)	F9999		

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F9999	Continued From page 26 300.1210a) 300.1210b)2)3) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a	F9999		

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F9999	Continued From page 27 resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These REGULATIONS are not met as evidenced by: Based on closed record review and staff interview, the facility failed to provide necessary care and services to avoid physical harm to one resident in the sample (R22) as evidenced by: 1) Failure to follow-up on a physician order and notification of physician in a timely manner regarding next PT/INR draw date for R22. 2) Failure to endorse needed lab requisition for PT/INR after R22 had identified abnormal bleeding levels taken and was on a new Coumadin order. From admission 04/30/07 thru 05/12/07 the facility did not monitor R22's bleeding/clotting time which caused R22 to have uncontrolled bleeding and hospitalization on 05/12/07. R22 had history of deep vein thrombosis and requires close monitoring of medical condition and bleeding time. 3) This lack of timely notification of physician, failure to monitor Coumadin bleeding/clotting levels and failure to assess resident condition	F9999		

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F9999	Continued From page 28 while giving anticoagulant drugs resulted in unavoidable hospitalization and worsening condition causing R22 to be sent to the emergency room. R22 ended up in the hospital with diagnosis of Coumadin Toxicity on 05/12/07. 4) Failure to provide necessary care and medical services resulted in an avoidable hospitalization and put resident at risk for bleeding. Findings include: R22 has diagnoses that include DVT (Deep Vein Thrombosis), Chronic Respiratory Failure, Sacral Decubitus, Diabetes Mellitus, and Muscular Wasting and Disuse Atrophy. Review of hospital records reflect that on 04/28/07 PT result is 22.5 H seconds (reference range 9.2- 11.8) and INR is 2.29 H (reference range is 0.87- 1.14). Review of record reflects that R22 was re-admitted to the facility on 04/29/07. Z4 (Physician) who was on call for Z3 (Attending Physician) was notified and gave an order to "Continue same Coumadin dose and to call Z3 (Attending Physician for R22) tomorrow for next PT/INR draw date." Z3 was never called the next day per documentation and per E1 (Administrator) interview on 05/17/07. The facility never obtained another PT and INR level. Review of nurses notes dated 05/12/07 2:00PM: "Resident with 2 blood soaked ABD pads over sacral decubitus when dressing changed. Also has 2 small dressing soaked with blood that were	F9999		

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F9999	Continued From page 29 covering small skin tear on right wrist." Z3 was notified of bleeding. Z3 ordered to send R22 to hospital emergency room. Review of facility's transfer form dated 05/12/07 reflects "Bleeding from sacral decubitus soaked thru 2 ABD pads this shift. Also oozing blood from right wrist skin tear." R22 was admitted to hospital on 05/12/07 with diagnosis of Coumadin toxicity. On 05/17/07 surveyor asked Z3 (Physician), "How do you monitor and what do you rely on when your resident is on Coumadin? Z3 stated, "With PT/INR, check daily. With R22, check weekly even within normal range because of her medical condition. If it is high or low, we will check it more often." Z3 further stated, "If a nurse calls me, and the lab results are in therapeutic range, I'll keep the same Coumadin order and check PT/INR in a week." Z3 was never notified of the abnormal levels and was not asked for when the next level of PT and INR to be drawn. Facility made a Care Plan for R22 and initiated on 03/21/07 about being at risk of adverse side effect of Anti-coagulant therapy which was updated on 05/02/07. Goal was to maintain lab values within normal range. Approaches include Monitor Lab values and report result to Physician. (A) 300.1210a)	F9999		

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F9999	Continued From page 30 300.1210b)1)2)3)5) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not	F9999		

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F9999	Continued From page 31 develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These REGULATIONS are not met as evidenced by: Based on observations, record review, and interviews, the facility has failed systemically to monitor and keep up their pressure sore program. The Director of Nurses used to be the wound care nurse, but has since has delegated the responsibility for assessment to the staff nurses who were not doing the assessments or treatments in a timely manner. This failure and lack of continuity of care placed all the residents with pressure sores in the facility at risk (total of 12 residents with pressure sores with 7 acquired in-house). The facility failed to identify new pressure ulcers, failed to re-assess and size wounds weekly, and failed to give treatments as ordered for 6 sampled residents with pressure sores. These failures led to 5 missed pressure sore treatments for R15, and development of a new ulcer without staff being aware for R6. R17 also developed a new unrecognized wound. R3 had no re-assessments for pressure ulcers. R13 had no treatment order or an assessment for an open sore. R19 had no treatment for an earlier identified excoriated area. Findings include: 1) R15 was admitted to the facility on 2/11/06	F9999		

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F9999	Continued From page 32 with diagnoses of End Stage Dementia, Lung Cancer, and Depression. Documentation in nurses notes dated 3/24/07 revealed a blister filled with fluid to right coccyx, measuring 2 x 2.2 cm was found. Review of facility initial skin alteration report staged the blister to the coccyx as a Stage II. Further documentation revealed no drainage and the surrounding skin had a normal appearance. R15's physician was notified and an order was obtained on 3/24/07: 1) For daily head to toe assessment. 2) Monitor Stage II (fluid filled) blister right coccyx area daily. 3) Apply EPC (extra protective creme to peri/sacral area after each incontinence episode every shift, CNA may apply). 4) Pressure relieving mattress. On 3/29/07, staff documented R15's coccyx had a blister and an open area, was cleansed with normal saline and allenym dressing was applied. There was no further documentation or re-assessment of R15's coccyx wound, nor was R15's physician notified of the wound's eventual opening. There is no evidence in chart that facility was monitoring this blister daily as ordered. On 3/30/07, Z2 (wound care specialist) saw R15 for an initial evaluation of R15's sacral/coccyx wound. Z2's Progress Notes identified "wound as a rapid onset blistered, necrotic pressure ulcer of sacrum-coccyx unable to stage. Suspect skin organ failure sincerely impaired tissue tolerance related to R/T progressive decline in condition, malnutrition. Z2's recommendation of care was for: 1) Pain assessment management. 2) Cleanse sacrum-coccyx ulcer with normal	F9999		

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F9999	Continued From page 33 saline. Apply Accuzyme with dry gauze dressing. Secure with Hypofix tape. Use Skin Prep to intact skin surrounding ulcer x 2 weeks. 3) Re-evaluation on wound rounds in 2 weeks. There were no measurements of R15's sacral-coccyx wounds done on 3/30/07. Review of the facility's initial skin alteration report, dated 4/8/07, identified R15's wound as a stage IV with measurements of 7 centimeters (cm) in length, 6 centimeters in width, 1.8 in depth., undermining 0.8 cm. at 6 clock. One more undated wound assessment sheet measures R15's wound as larger at 8 cm. (l) x 5 cm. (w) x 2 cm. depth. There is no mention of the previous undermining or tunneling of the wound. Another undated wound assessment identifies R15's coccyx wound as Stage IV wound with no measurements Facility failed to offer consistent assessments with clear measurements and consistency in their observations as well and put down the dates of their observations. On 5/16/07, surveyor observed R15 wound treatment done by E13 (staff nurse). E13 stated she had done R15's dressing in the morning. During observation, the dressing was not dated as per facility policy and protocol. E13 stated she did not have the calcium alginate rope dressing available during the previous wound change, but did find the alginate rope on the cart for this new wound change. E13 stated she did not have accuzyme ointment for this new wound change, and it would have to be re-ordered. Surveyor observed E13 cleanse the wound and apply the calcium alginate rope dressing. Facility failed to have necessary treatments available and used for each dressing change.	F9999		

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F9999	Continued From page 34	F9999		

Review of Physician's Orders revealed an order to cleanse sacral ulcer with wound cleanser, apply accuzyme to necrotic area of wound, then pack with calcium alginate rope dressing, cover with abdominal pad, change daily, and prn times 2 weeks. Review of R15's Administration Record lacks documentation that R15 received the Calcium Alginate rope dressing as ordered on 5/8/07, 5/9/07, 5/12/07,5/13/07, 5/14/07, and 5/15/07.

E2 stated in interview on 5/16/07 that the wound specialist sees all new pressure ulcers in the facility during rounds. E2 stated the wound specialist was going to see R15 for a Stage II to coccyx. E2 further stated that she does not recall what R15's wound looked like on 3/30/07.

On 5/17/07, after prompting by surveyor, R15's sacral coccyx wound was re-measured by E2 (DON) and E12 and revealed the following measurements:
9.5 cm (l) x 9 cm (w) 2.8 depth. Facility's last dated wound measurement was 4/8/07.

2) R6's diagnoses includes Aphasia and Cerebral Vascular Accident. Review of R6's Minimum Data Set (MDS) of 3/15/07 reveals R6 requires extensive assistance with care. Section M. 1) Ulcers: reveals R6 had a stage II ulcer in March and review of R6's MAR revealed R6's wound healed on 3/21/07.

Surveyor asked staff E11 (RN) and E2 (DON) if R6 has had any recent breakdown. E11 stated "I think she used to have one on her ankle." R6 was observed sitting in wheel chair with feet dependent on floor and wearing socks.

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F9999	Continued From page 35 During skin check requested by surveyor, E2 and E11 found an open area to R15's outer aspect of left ankle with erythema and epithelialization with scant amount of drainage. There were no measurements of R6's Stage II wound on the initial skin alteration record. R6 was assessed as "at risk" on the Braden Scale in March 2007. R6's care plan interventions require facility to monitor skin condition with ADL care daily and to report abnormalities which was not done for this resident on skin risk. A preventive measure noted on R6's medication administration record was for R6 to have a cushion in her wheelchair. There was no cushion observed in her chair on 5/15/07. An order was obtained on 5/15/07 to: 1) Cleanse wound outer aspect of left ankle with dermal wound cleanser. Apply Allevyn dressing change every 3 days and as necessary until healed. 2) Daily head to toe skin assessment. On 5/16/07 an orders for bilateral heel protectors on in bed, to elevate both heels with pillow in bed off load pressure, and a pressure reduction mattress were obtained. 3) R3's diagnoses include hypertension, neurologia, and hypothyroidism. R3 is dependent on staff for care. Review of R3's initial skin alteration record of 2/16/07 already revealed an ulcer at Stage III wound to right heel with moderate amount of serosanguinous drainage, measuring 5 cm circumferential. There were no further assessments to the right heel until 3/4/07 which measured 5 cm x 5 cm; an undated	F9999		

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F9999	Continued From page 36 assessment measuring 4 x 4; an assessment dated 3/29/07 measuring 3cm x 3cm. The last assessment of the right heel documented by the facility was done on 4/19/07 measuring .5 cm. in (l) x 1.2 (w). There was no consistent documentation or assessment of this resident's heel. R3 was identified with a Stage II to anterior right foot on 2/16/07 measuring 4 cm x 3.5 cm. Assessments were done weekly until 4/19/07 with the wound measuring at 2 cm x 3.5 cm. No further assessments were done after this until prompting of surveyor. 4) R17's diagnoses include Dementia and history of cellulitis of both lower extremities. Review of R17's wound assessment sheets reveal a stage II to right medial ankle on 4/5/07 measuring 1 cm x 1.3cm. The next assessment dated 4/18/07 had no measurements. On 4/21/07 measurements were 1 cm. (l) x 4 cm (w). Two weeks later on 5/12/07 again no measurements were obtained. On 5/17/07 measurements revealed an increase in the wound 1.6 cm. (l) x 1.9 cm. (w). On 5/16/07 surveyor noted, while observing wound care with E2, a new open area was observed to R17's right lower ankle measuring 0.3 cm. (l) x 0.5 cm. (0.5) which facility had not monitored. E2 classified the area as a skin tear. 5) Based on observation on 05/15/07 at 1:50 PM, with E11 (nurse in charge of R13) and E12 (CNA/Certified Nursing Assistant) in charge of the resident, R13 was observed after he was put back to bed. R13 was noted with disposable incontinent pad filled with soft stool. After cleaning the stool, a 1 cm. by 1 cm. stage II open	F9999		

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F9999	Continued From page 37 sore was noted between the scrotum and the anus. E12 (CNA) was asked if she had noted this open sore before. E12 indicated that she had observed this open sore last week and described the wound as actively bleeding. E12 then indicated that she had reported this to E11 that same day. E11 (nurse) acknowledged that the CNA did tell her about it but she failed to implement skin monitoring and treatment. Currently, there is no dressing noted on the open sore as it was exposed to stool and urine incontinence. Review of record show there is no documentation of this open sore being reported after May 3, 2007. The staff has not assessed for proper treatment after changes in the open sore were noted. There was no documentation of this change, and the physician was not notified. The facility has not used acceptable prevention measures to prevent the open sore from getting worse through timely checks for incontinence as needed. E12 (CNA) had indicated that R13 was gotten up around 8:00 AM for breakfast and put back in bed at 1:10 PM. When checked at 1:50 PM, R13's incontinent pad contained incontinence of stool which was noticeably dried in the pads and on R13's anal and scrotal area. 6) R19 was observed on 05/16/07 at 1:30 PM with dressing dated 05/16/07 on R19 's right thigh, buttocks, and right lower buttocks. R19 is on a fluidized therapy bed. The bed sheet had stool stain and the bed had blood stain. Upon	F9999		

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MANORCARE AT ROLLING MEADOWS	4225 KIRCHOFF ROAD ROLLING MEADOWS, IL 60008

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F9999	Continued From page 38 opening incontinence pad with E4 (ADON/Assistant Director of Nursing) stool was noted on the meatus and groin area. The diaper was stained with stool. E4 (ADON) cleaned the groin and the scrotal area. During cleaning, R19 was grimacing showing pain while the scrotum was being washed. The scrotum and perineal area were noted excoriated and reddened. No treatment was noted, and there was no documentation of the condition of this area. E5 (Nurse in charge) acknowledged that there was redness in the area when dressings were changed earlier and resident had been identified as irritated and reddened. E2 stated in interview on 5/21/07 that prior to becoming DON she was the ADON and monitored the facility wounds and treatments. E2 stated the night nurses are now to be doing wound assessments weekly for all residents on a scheduled night shift, but that this is not always being done. E2 stated since becoming DON she had not been reviewing the wound assessments for accuracy and completion by staff. Facility skin management guideline under Quality Improvement Monitoring requires on-going body audits and skin and or wound evaluations. The facility's failure to monitor skin and assess wounds resulted in 7 of 12 residents acquiring new wounds. The staff failed to assess wounds weekly with measurements and failed to ensure treatments were provided as ordered. (A)	F9999		